NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2003

MDR Tracking #: M2-03-0851-01-SS
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained a work-related injury on ___ when she injured her lower back while lifting boxes. On 11/15/95 the patient underwent bilateral laminectomies, foraminotomies, and nerve root decompression from L3 to S1. On 04/22/99 she underwent an anterior lumbar interbody fusion, removal hardware from her 1995 surgery, and a fusion at L4-5 and L5-S1 with total diskectomies and insertion of titanium bone cages. With increased symptomatology, the treating physician is recommending that the patient undergo a posterior decompression at L3-4.

Requested Service(s)
Posterior decompression at L3-4

Decision
It is determined that the posterior decompression at L3-4 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The medical record documentation does not substantiate evidence of spinal stenosis. The radiologist's report of the myelogram/CT scan performed on 09/16/02 does not support the diagnosis of spinal stenosis. There is evidence of a mild disc bulge and severe facet joint arthropathy; however, there is no evidence of central canal stenosis or nerve root impingement. The thecal sac is noted to be adequate at the L3-4 level. Therefore, the posterior decompression at L3-4 is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c))

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,